STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #1	445235	A. BUILDING _____ B. WING _____	C 08/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULEVARD TERRACE REHABILITATION AND NURSING HOME	1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint investigation #30255 and #30291 were completed on August 21 - 22, 2012. No deficiencies were cited related to complaint investigation #30255. Deficiencies were cited related to complaint investigatin #30291 under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow physician's orders for three (#3, #4, #10, and #13) of eighteen residents reviewed. The findings included: Resident #3 was admitted to the facility on August 6, 2012, with diagnoses including Left Foot Transmetatarsal Amputation, Cellulitis Left Foot, Osteomyelitis, Diabetes, Chronic Pain Syndrome, Congestive Heart Failure, Peripheral Vascular Disease, and Peripheral Neuropathy. Medical record review of a physician's order, signed by the resident's physician, dated August	F 309	**F309** **1. Corrective action for residents affected:** a.) The Antibiotic order for Resident #3 was changed to Avelox on 8/17/12 and RN#1 was educated by the Nurse Educator on 8/22/12 on properly filling out telephone orders to reflect the correct ordering Physician. Resident assessed by the Unit Manager on 8/17/12 with no adverse outcome. b.) Physician notified of Medication Error to Resident #4 on 8/8/12 by the Unit Manager. Resident assessed by the Unit Manager on 8/8/12 with no adverse outcome. c.) Physician notified of Medication Error to Resident #10 by Unit Manager on 8/20/12. Resident assessed by the Unit Manager on 8/20/12 with no adverse outcome. d.) Physician notified of Medication Error by the Unit Managerto Resident #13 on 8/20/12. Resident assessed by the Unit Manager on 8/20/12 with no adverse outcome. **2. Identification of others who could be affected by the deficient practice:** The Director of Nursing and/or Unit Managers audited all physician orders on current residents for compliance 8/23/12 - 9/5/12. No other residents found to be affected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9-6-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

SEP 10 2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445235	A. BUILDING _____ B. WING _____	C 08/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULEVARD TERRACE REHABILITATION AND NURSING HOME	1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130

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F 309	Continued From page 1 8, 2012, revealed "D/C (discontinue) Levofloxacin (antibiotic) 500 mg (milligrams) 1 po (by mouth) q (every) day til 9/1/12, Avelox (antibiotic) 400 mg 1 po q day (as per hosp (hospital) orders) D/C Metronidazole (for bacterial infections caused by anaerobic microorganisms) 500 mg tid until 9/1/12..." Medical record review of a physician's order dated August 9, 2012, revealed "D/C Avelox 400 mg, Levafloxacin 500 mg PO daily til (until) 9/1/12 for skin infection, Metronidazole 500 mg 3 times a day til 9/1/12 for skin infection. Continued review of the August 9, 2012, physician's order revealed Registered Nurse (RN #1) had received this order from the infectious disease physician. Continued review of the physician's order dated August 9, 2012, revealed in a different had writing a notation stating "Dr. (infectious disease) did not give this order..." Medical record review of the August 2012, Medication Administration Record revealed the resident received Levofloxacin 500 mg on August 10-17, 2012, and Metronidazole 500 mg three times a day on August 10-17, 2012. Continued review of the August 2012, Medication Administration Record revealed the resident did not received the Avelox as ordered on August 10 - 17, 2012. Observation on August 21, 2012, at 10:20 a.m., revealed the resident lying on the bed with a dressing on the left foot. Interview on August 22, 2012, at 7:30 a.m., with the physician in the conference room, revealed the wound on the resident's left foot was	F 309	**3. Measures put in place to ensure deficient practice does not reoccur:** The Nurse Educator inserviced licensed Nurses on Medication Administration, Telephone Orders, Input of orders into the electronic medical system and reviewing orders on new admits for accuracy 8/23/12 - 9/7/12.. New Nurses will be inserviced by the Nurse Educator during the orientation process. **4. Systems to monitor the effectiveness:** a.) The Director of Nursing, Assistant Director of Nursing, Unit Managers, and Medical Records will audit new admit orders, telephone orders, and the Electronic Medical System for accuracy, for a total of 20 residents weekly for 4 weeks, then twice monthly for 2 months and/or until 100% compliant. b.) Findings will be reported monthly by the Director of Nursing to the Quality Assurance Performance Improvement Committee comprised of: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, and Admissions Coordinator.	9/12/12 ~~10/2/12~~ per administrator

SEP 10 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 2	F 309		

improving, decreasing in size and there was less drainage from the foot. Continued interview revealed Levofloxacin was in the same class of antibiotics as the Avelox, and confirmed the Levofloxacin with the Metronidazole were effective medications to treat the resident's wound, however the Avelox was the medication preferred by the physician.

Interview on August 22, 2012, at 8:20 a.m., with RN #1 in the conference room, revealed RN #1 had received the order to discontinue the Avelox, and start Levofloxacin and Metronidazole from the infectious disease physician's nurse on August 7, 2012. Continued interview confirmed RN #1 did not receive an order on August 9, 2012, from the infectious disease physician to discontinue the Avelox and to administer the Levofloxacin and Metronidazole. Continued interview confirmed the resident received the Levofloxacin and the Metronidazole from August 10 - 17, 2012, without a physician's order. Continued interview confirmed the resident did not received the Avelox August 10 -17, 2012, as ordered by the physician.

Resident #4 was admitted to the facility on July 17, 2012, with diagnoses including Peripheral Vascular Disease, Chronic Obstructive Pulmonary Disease, Arthritis, and Congestive Heart Failure. Medical record review revealed the resident was discharged home on August 16, 2012.

Medical record review of a physician's order dated August 7, 2012, revealed "...Miralax 17 g (grams) po tonight x (times) 1 then qd (every day) prn (as needed)."

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F 309	Continued From page 3 Medical record review of the August 2012, Medication Administration Record revealed no documentation the Miralax was administered on August 7, 2012. Medical record review of a physician's note dated August 8, 2012, revealed "...Constipation - did not receive Miralax ordered last PM (evening)..." Interview on August 22, 2012, at 9:15 a.m., with the Assistant Director of Nursing in the conference room, confirmed the resident did not receive the Miralax as ordered on August 7, 2012. Resident #10 was admitted to the facility on August 17, 2012, with diagnoses including Diabetes and End Stage Renal Disease. Medical record review of the admission physician's orders dated as signed by the hospital physician on August 18, 2012, (per Director of Nursing the physician must have signed the wrong date) revealed the resident was to receive Novolog sliding scale insulin before meals and at bedtime as follows: Glucose 150 - 200, 4 units; Glucose 201 - 250, 8 units; Glucose 251 - 300, 12 units; Glucose 301 - 350, 16 units; Glucose 351 - 400, 20 units and call the physician. Medical record review of the August 2012, Medication Administration Record revealed the resident's glucose was checked and insulin administered before meals and at bedtime using the following parameters: Glucose 201 - 250, 2 units; Glucose 251- 300, 4 units; Glucose 301 - 350, 6 units; Glucose 351 - 400, 8 units; and	F 309		

SEP 10 2012

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F 309	Continued From page 4 greater than 400, 10 units and notify the physician. Medical record review revealed no physician's order to change the parameters for insulin administration. Interview on August 22, 2012, at 12:05 p.m., with the Director of Nursing, in the conference room, revealed the resident's sliding scale insulin was changed to the facililty's Standing Orders for sliding scale insulin upon admission to the facility, and confirmed there was no physician's order to change the sliding scale insulin to the facility's standing orders. Interview on August 22, 2012, at 12:15 p.m., with the physician/Medical Director, in the conference room, revealed the physician had not approved the facility's standing orders for sliding scale insulin administration. Resident #13 was admitted to the facility on August 18, 2012, with diagnoses including Glaucoma, Atrial Fibrillation, and Congestive Heart Failure. Medical record review of the admission physician orders dated August 16, 2012, from the hospital, revealed the resident was to receive Lumigan (antiglaucoma) 0.03% ophthalmic solution. Medical record review of a physician's order dated August 20, 2012, revealed "Lumigan 1 gtt (drop) to ea. (each) eye q (every) hs (hour of sleep)..." Medical record review of the August 2012,	F 309		

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F 309	Continued From page 5 Medication Administration Record revealed no documentation the resident received the Lumigan on August 18 or 19, 2012. Interview on August 22, 2012, at 11:00 a.m., revealed the physician's order for Lumigan was not transcribed from the admission orders and confirmed the resident did not receive the Lumigan on August 18 and 19, 2012, as ordered by the physician.	F 309		
F 333 SS=D	C/O #30291 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to prevent a significant medication error for one (#10) of eighteen residents reviewed. The findings included: Resident #10 was admitted to the facility on August 17, 2012, with diagnoses including Diabetes, and End Stage Renal Disease. Medical record review of the admission physician's orders dated as signed by the hospital physician on August 18, 2012, (per Director of Nursing the physician must have signed the wrong date) revealed the resident was to receive Novolog sliding scale insulin before meals and at	F 333	**F333** **1. Corrective action for residents affected:** Physician notified of Medication Error to Resident #10 by the Unit Manager on 8/20/12. Resident assessed by the Unit Manager with no adverse outcome. **2. Identification of others who could be affected by the deficient practice:** All Sliding Scale Insulin orders were audited by the Director of Nursing and Unit Managers on 8/23/12 for accuracy and found to be compliant. No other residents found to be affected. **3. Measures put in place to ensure deficient practice does not reoccur:** The Nurse Educator inserviced licensed Nurses on Sliding Scale Insulin orders and Medication Administration 8/23/12 - 9/7/12. New Nurses will be inserviced by the Nurse Educator during the orientation process.	

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F 333	Continued From page 6 bedtime as follows: Glucose 150 - 200, 4 units; Glucose 201 - 250, 8 units; Glucose 251 - 300, 12 units; Glucose 301 - 350, 16 units; Glucose 351 - 400, 20 units and call the physician. Medical record review of the August 2012, Medication Administration Record revealed the resident's glucose was checked and insulin administered before meals and at bedtime using the following parameters: Glucose 201 - 250, 2 units; Glucose 251- 300, 4 units; Glucose 301 - 350, 6 units; Glucose 351 - 400, 8 units; and greater than 400, 10 units and notify the physician. Medical record review revealed no physician's order to change the parameters for insulin administration. Medical record review of the August 2012, Medication Administration Record revealed the resident received Novolog sliding scale insulin as follows: on August 17, 2012, at 9:00 p.m., the resident's blood sugar was 162 and no insulin was administered; on August 18, 2012 at 7:30 a.m., the resident's blood sugar was 280 and 4 units of insulin was administered; on August 18, 2012, at 11:30 a.m., the resident's blood sugar was 287 and 4 units of insulin was administered; on August 18, 2012, at 4:30 p.m., the resident's blood sugar was 361 and 8 units of insulin was administered; on August 18, 2012, at 9:00 p.m., the resident's blood sugar was 259 and 4 units of insulin was administered; on August 19, 2012, at 7:30 a.m., the resident's blood sugar was 200 and no insulin was administered; on August 19, 2012, at 11:30 a.m., the resident's blood sugar was 248 and 2 units of insulin was administered;	F 333	**4. Systems to monitor the effectiveness:** a) The Director of Nursing, Assistant Director of Nursing, Unit Managers, and Medical Records will audit new admission orders and telephone orders with sliding scale insulin for accuracy, for a total of 20 residents weekly for 4 weeks, then twice monthly for 2 months and/or until 100% compliant. b) Findings will be reported monthly by the Director of Nursing to the Quality Assurance Performance Improvement Committee comprised of: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, and Admissions Coordinator. 9/18/12 ~~10/2/12~~ Readmitted KG	

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F 333	Continued From page 7 on August 19, 2012, at 4:30 p.m., the resident's blood sugar was 246 and 2 units of insulin was administered; on August 19, 2012, at 9:00 p.m., the resident's blood sugar was 278 and 4 units of insulin was administered; and on August 20, 2012, at 7:30 a.m., the resident's blood sugar was 196 and no insulin was administered. Medical record review of a physician's order dated August 20, 2012, revealed "SS (sliding scale) Novolog (insulin): 0 - 60, 0 (insulin); 61 - 150, 0 (insulin); 151 - 200, 2u (units) sq (subcutaneous); 201 - 250, 4u sq; 251 - 300, 6u; 301 - 350, 8u sq; 351 - 400, 10u; 401+, 12u sq." Observation on August 22, 2012, at 8:50 a.m., revealed the resident lying on the bed, awake and had just completed the breakfast meal. Interview on August 22, 2012, at 12:05 p.m., with the Director of Nursing, in the conference room, revealed the resident's sliding scale insulin was changed to the facililty's Standing Orders for sliding scale insulin upon admission to the facility and confirmed there was no physician's order to change the sliding scale insulin to the facility's standing orders. Interview on August 22, 2012, at 12:15 p.m., with the physician/Medical Director, in the conference room, revealed the physician had not approved the facility's standing orders for sliding scale insulin administration.	F 333		
F 386 SS=D	C/O #30291 483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS	F 386		

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F 386	Continued From page 8 The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility documentation review, and interview, the facility failed to follow the written agreement in place with the Medical Director regarding the use of the physician's signature stamp. The findings included: Resident #18 was admitted to the facility on May 16, 2012, with diagnoses including Acute and Chronic renal failure, History of a Cerebral Vascular Accident and Diabetes Mellitus. Medical record review revealed three telephone orders dated June 1, 2012, and one telephone order dated May 7, 2012, with the former Medical Director's signature stamp and no date or time to indicate the physician had reviewed and approved the orders. Review of facility documentation dated February 14, 2005, regarding the authorization of the rubber signature stamp revealed "...I am the only individual in control of and using this signature and/or date stamp...when this stamp is placed on	F 386	**F386** **1. Corrective action for residents affected:** Previous Medical Director removed stamp from facility on 7/15/12. **2. Identification of others who could be affected by the deficient practice:** Stamps are no longer a practice in facility. All resident orders assessed by Director of Nursing on 8/23/12 and no longer affected by this practice. **3. Measures put in place to ensure deficient practice does not reoccur:** The Nurse Educator completed an inservice with the current medical director regarding signing and dating all orders in black ink on 8/29/12. All licensed nurses are aware and inserviced by the Nurse Educator that rubber stamp no longer a practice in this facility 8/23/12 - 9/12/12. New nurses will be inserviced by the Nurse Educator during orientation. **4. Systems to monitor the effectiveness:** a.) Director of Nursing and/or Medical Records Director will audit 20 telephone orders for physician signature/date in black ink weekly for 4 weeks, and then twice monthly for 2 months and/or until 100% compliant.	

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F 386	Continued From page 9 documentation, I am attesting that I personally stamped this document on the date indicated..." (document signed by the former medical director). Interview on August 22, 2012, at 11:30 a.m. with Licensed practical Nurse (LPN) #2 revealed the LPN routinely used the physician's signature stamp on medical record documents and physician's orders. The LPN stated the stamp is used in the medical records office, by the LPN following the medical director's review of orders, lab results, and other medical record documents. The LPN confirmed the orders were not dated to indicate the medical director had reviewed and approved the physician's orders and the physician was not the only person with access to the signature stamp. Telephone interview on August 22, 2012, at 12:20 p.m., with the former medical director, confirmed the physician was aware the medical records LPN had access to and used the signature stamp on medical record documents.	F 386	b.) Findings will be reported monthly by the Director of Nursing to the Quality Assurance Performance Improvement Committee comprised of: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, and Admissions Coordinator.	10/2/12
F 425 SS=D	C/O #30291 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services	F 425	**F425** **1. Corrective action for residents affected:** Physician notified of Medication Error to resident #3 by the Unit Manager on 8/7/12. Resident assessed by Unit Manager on 8/7/12 with no adverse outcome. **2. Identification of others who could be affected by the deficient practice:** Audit of current residents was done by the Unit Mangers on 8/23/12 for availability of medication and all were found to be compliant. No other resident found to be affected..	

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F 425	Continued From page 10 (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide timely pharmacy services for one (#3) of eighteen residents reviewed. The findings included: Resident #3 was admitted to the facility on August 6, 2012, with diagnoses including Left Foot Transmetatarsal Amputation, Cellulitis Left Foot, Diabetes, Chronic Pain Syndrome, Congestive Heart Failure, Peripheral Vascular Disease, and Peripheral Neuropathy. Medical record review of the admission orders dated August 6, 2012, revealed the resident was to receive Avelox (antibiotic) 400 mg (milligrams), by mouth every day, through September 1, 2012. Medical record review of the August 2012, Medical Administration Record revealed the resident did not receive the Avelox 400 mg and was on order on August 7, 2012.	F 425	**3. Measures put in place to ensure deficient practice does not reoccur:** **a.)** In-service provided to licensed nursing staff by Nurse Educator 8/23/12 - 9/7/12 regarding telephone notification of pharmacy of new orders. New staff to be inserviced by the Nurse Educator during the orientation process. **b.)** In-service provided to licensed nursing staff by Nurse Educator 8/23/12 - 9/7/12 regarding MD notification of unavailable medications and obtaining order for therapeutic alternative available in emergency facility meds. New staff to be inserviced by the Nurse Educator during the orientation process. **4. Systems to monitor the effectiveness:** **a.)** Director of Nursing and/or Unit Manager to audit MAR of 3 residents weekly for 4 weeks, then twice monthly for 2 months and/or until 100% compliant for availability of ordered medications. b.) Findings will be reported monthly by the Director of Nursing to the Quality Assurance Performance Improvement Committee comprised of: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, and Admissions Coordinator. 9/12/12 ~~10/2/12~~	

Pr admin istrator

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	445235	A. BUILDING _____ B. WING _____	C 08/22/2012

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F 425	Continued From page 11 Telephone interview on August 23, 2012, at 9:10 a.m., with the Director of Nursing confirmed the Avelox was not available for administration on August 7, 2012. C/O #30291	F 425		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain laboratory levels as ordered for two (#12, #16) residents of eighteen residents reviewed. The findings included: Resident #12 was admitted to the facility on July 1, 2011, with diagnoses including Depressive Disorder, Chronic Obstructive Pulmonary Disease, and Hypertension. Medical record review of a physician's order dated July 20, 2012, revealed "...BMP (Basic Metabolic Profile), Mg (Magnesium) 7/26-Diuretic therapy..." Medical record review of a laboratory report dated July 26, 2012, revealed "...Potassium 2.8... (reference range) 3.4-5.1...Critical Value...Called to (staff member)..." Further review revealed no	F 502	**F502** **1. Corrective action for residents affected:** a.) Physician notified by the Unit Manager and lab drawn on 8/20/12 as ordered on Resident #12 with lab value found to be within normal range. b.) Physician notified by the Unit Manager and orders received to draw lab on 8/20/12 and found to be within normal range. c.) Hospital Lab Results obtained by the Unit Manager for Resident # 16 on 8/22/12 and found to be within normal range. **2. Identification of others who could be affected by the deficient practice:** a.) Director of Nursing, Assistant Director of Nursing, and Unit Managers audited current lab orders starting 8/23/12 - 9/7/12. No other residents found to be affected. **3. Measures put in place to ensure deficient practice does not reoccur:** a.) Licensed nurses inserviced by Nurse Educator 8/23/12 - 9/7/12 on utilization of lab calendars. New nurses will be inserviced by the Nurse Educator during the orientation process.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 502	Continued From page 12 Magnesium level had been obtained on July 26, 2012. Medical record review of a physician's order dated July 26, 2012, revealed "...Potassium 40 MeQ (milliequilvents) now...Potassium 20 MeQ daily...(Potassium) level 7/31/12..." Medical record review revealed no Potassium level had been obtained on July 31, 2012. Medical record review of a physician's order dated August 20, 2012, revealed "...Stat (now) K (potassium) level...pt (patient) (with) (low) K..." Medical record review of a laboratory report dated August 20, 2012, revealed "...Potassium 4.5... (reference range) 3.4-5.1..." Interview on August 22, 2012, at 11:30 a.m., with the Director of Nursing, in the conference room, confirmed the Magnesium level had not been obtained on July 26, 2012, and the Potassium level had not been obtained on July 31, 2012. Resident #16 was admitted to the facility on February 25, 2003, with diagnoses including Diabetes, Esophageal Reflux, and Anxiety. Medical record review of a physician's order dated August 13, 2012, revealed "...BMP (Basic Metabolic Profile) Mg (Magnesium) Fri (Friday) (August 17, 2012) am re (regarding) (low) K..." Medical record review revealed no laboratory results for a BMP and Mg level on August 17, 2012.	F 502	**4. Systems to monitor the effectiveness:** a.) Lab orders are to be compared to calendar by Director of Nursing and/or Unit Managers on 10 lab orders weekly for 4 weeks and then twice monthly for 2 months and/or until 100% compliant. b.) Findings will be reported monthly by the Director of Nursing to the Quality Assurance Performance Improvement Committee comprised of: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, and Admissions Coordinator. 9/12/12 ~~10/2/12~~ Per administrator KV	

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F 502	Continued From page 13 Interview on August 22, 2012, at 12:15 p.m., with the Director of Nursing (DON), in the conference room, confirmed the BMP and Mg had not been obtained as ordered on August 17, 2012.	F 502		
F 505 SS=D	C/O #30291 483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify the physician timely of laboratory results for one (#11) resident of eighteen residents reviewed. The findings included: Resident #11 was admitted to the facility on November 12, 1998, with diagnoses including Atrial Fibrillation, and Congestive Heart Failure. Medical record review of a laboratory report dated August 18, 2012, revealed "...Bacterial Culture Urine...Final Report Verified: 08/18/2012... (greater than) 100,000...Enterococcus species..." Medical record review of a physician's order dated August 20, 2012, revealed "...Levaquin (antibiotic) 500 mg (milligrams) 1 po (by mouth) q (every) day x 7 d...UTI (urinary tract infection)..." Interview on August 22, 2012, at 12:15 p.m., with	F 505	**F505** **1. Corrective action for residents affected:** Physician notified by Licensed Nurse and order obtained for medication for Resident #11 on 8/20/12. Resident assessed by Unit Manager on 8/20/12 with no adverse outcome. **2. Identification of others who could be affected by the deficient practice:** Director of Nursing and Unit Managers conducted an audit of labs 8/23/12 - 9/7/12 for notification of physician. No other resident found to be affected. **3. Measures put in place to ensure deficient practice does not reoccur:** Licensed nurses educated by the Nurse Educator on timely notification of physician/physician on call 8/23/12 - 9/7/12. New nurses to be inserviced by Nurse Educator during the orientation process.	

F505

4. Systems to monitor the effectiveness:

a.) Director of Nursing and/or Unit Managers to review labs ordered on 10 residents weekly for 4 weeks, then twice monthly for 2 months and/or until 100% compliant for notification of Physician and any orders received.

b.) Findings will be reported monthly by the Director of Nursing to the Quality Assurance Performance Improvement Committee comprised of: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, and Admissions Coordinator.

~~10/2/12~~

9/12/12

Per administrator

KG

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F 505	Continued From page 14 the Medical Director in the conference room, confirmed was not notified of the urine culture results until August 20, 2012 (two day delay).	F 505		
F 514 SS=D	C/O #30291 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain an accurate medical record for one resident (#3) and failed to maintain a complete medical record for one resident (#18) of eighteen residents reviewed. The findings included: Resident #3 was admitted to the facility on August 6, 2012, with diagnoses including Left Foot Transmetatarsal Amputation, Cellulitis Left Foot, Osteomyelitis, Diabetes, Chronic Pain Syndrome, Congestive Heart Failure, Peripheral Vascular	F 514	**F514** **1. Corrective action for residents affected:** a.) The Antibiotic order for Resident #3 was changed to Avelox on 8/17/12 and RN#1 was educated by the Nurse Educator on 8/22/12 on properly filling out telephone orders to reflect the correct ordering Physician. Resident assessed by the Unit Manager on 8/17/12 with no adverse outcome.. b.) Discharge summary completed on Resident #18 by Licensed Practical Nurse on 8/23/12. **2. Identification of others who could be affected by the deficient practice:** a.) An audit for completion of discharge summaries on residents discharged from the facility in the last 90 days was done by the Medical Records Director on 8/23/12. b.)The Director of Nursing and/or Unit Managers audited all physician orders on current residents for compliance 8/23/12 - 9/5/12. No other residents found to be affected	

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F 514	Continued From page 15 Disease, and Peripheral Neuropathy. Medical record review of a physician's order dated August 9, 2012, revealed "D/C (discontinue) Avelox (antibiotic) 400 mg (milligrams), Levafloxacin (antibiotic) 500 mg PO (by mouth) daily til 9/1/12 for skin infection, Metronidazole (for bacterial infections caused by anaerobic microorganisms) 500 mg 3 times a day til 9/1/12 for skin infection. Continued review of the August 9, 2012, physician's order indicated Registered Nurse (RN) #1 had received this order from the infectious disease physician. Continued review of the physician's order dated August 9, 2012, revealed in a different hand writing a notation stating "Dr. (infectious disease) did not give this order..." Interview on August 22, 2012, at 8:20 a.m., with RN #1 in the conference room, confirmed RN #1 did not receive an order on August 9, 2012, from the infectious disease physician to discontinue the Avelox and to administer the Levofloxacin and Metronidazole. Resident #18 was admitted to the facility on May 16, 2012, with diagnoses including Acute and Chronic renal failure, History of a Cerebral Vascular Accident and Diabetes Mellitus. Medical record review revealed the resident was discharged to the hospital on June 1, 2012, and expired in the hospital on June 5, 2012. The facility failed to include a discharge summary detailing the resident's medical treatment and condition during the course of the resident's stay at the facility May 16, 2012 through June 1, 2012.	F 514	**3. Measures put in place to ensure deficient practice does not reoccur:** a.) The Nurse Educator inserviced all licensed nurses on telephone and clarification orders 8/23/12 - 9/7/12. New nurses to be inserviced by the Nurse Educator during the orientation process. b.) The Nurse Educator inserviced Medical Records on completion and closing of discharge charts on 9/7/12. c.) The Nurse Educator inserviced licensed nursing on completion of discharge summaries on day of discharge from the facility 8/23/12 - 9/7/12. New nurses to be inserviced by the Nurse Educator during the orientation process. **4. Systems to monitor the effectiveness:** a.) The Director of Nursing and/or Unit Managers will audit telephone orders and the Electronic Medical System for accuracy, for a total of 20 residents weekly for 4 weeks, then twice monthly for 2 months and/or until 100% compliant. b.) Director of Nursing and/or Medical Records Director will audit discharged resident's charts for the presence of discharge summary. c.) Findings will be reported monthly by the Director of Nursing to the Quality Assurance Performance Improvement Committee comprised of: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services	

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F 514	Continued From page 16 Interview with the Director of Nursing and Licensed Practical Nurse #2 on August 22, 2012, at 10:30 a.m., in the medical records office, confirmed no discharge summary had been completed for resident #18, following the resident's discharge to the hospital on June 1, 2012. Continued interview confirmed without the discharge summary the resident medical record was incomplete. C/O #30291	F 514	Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, and Admissions Coordinator.	9/12/12 ~~10/2/12~~ Per administrator KB